

C.R. Lait Optical and Eye Associates  
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Acknowledgement of Receipt "AOR" or Notice of Privacy Practices "NPP"

By signing my name below, I acknowledge that:

1. I have been informed of this office's compliance with HIPAA regulations.
2. I understand that, upon request, I have the right to receive a copy of the entire privacy policy for this office at any time. Financial payment for any copying involved will be required, but will not exceed one dollar (\$1.00) per page.
3. I have received or have been offered a copy of this office's "NPP".
4. I understand that I have the right to review my protected health information at any time, upon request. I also understand that I have the right to submit a written request for a change in policy regarding my personal health information. I also have the right to file a complaint if I feel my rights have been violated or policies have not been followed.
5. If there is any particular party or individual that I, specifically, would like my information to be released to, I have listed the party or individual at the bottom of this page.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_